

# Sildenafil (Viagra®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP).

Express Scripts is the TMOP contractor for DoD.

Your patient receives their prescription drug benefit from the Department of Defense (DoD). The DoD prescription drug benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage can be provided. Before giving the prescription to the patient, please make a copy of this form, complete the following questions and give the completed form, along with the prescription, to the patient. Please instruct the patient to send this completed form, along with the prescription, to Express Scripts for processing.

If Express-Scripts already has your patient's prescription and has requested that you complete this form, the completed form may be faxed to: (877) 895-1900 (toll-free) or (602) 586-3911 (commercial). A copy of this form and explanations of the underlying clinical rationale and criteria for approval are available at [http://www.pec.ha.osd.mil/PA\\_Criteria\\_and\\_forms.htm](http://www.pec.ha.osd.mil/PA_Criteria_and_forms.htm).

Drug for which Prior Authorization is requested:

Sildenafil (Viagra®)

**Step 1** Please complete patient and physician information (Please Print)

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Patient Name:

Physician Name:

Address:

Address:

Member #:

Phone #:

Secure Fax #:

**Step 2** Please complete the clinical assessment

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1. Is the patient receiving concomitant therapy with a nitrate?

If yes, benefit not approved. Use of sildenafil is contraindicated in patients receiving nitrates.  
If no, proceed to Question 2.

☐ Yes

☐ No

2. Is sildenafil being prescribed for the treatment of sexual dysfunction?

If yes, proceed to Question 3.

If no, please complete the following information and then proceed to Step 3 to sign and date the form.

☐ Yes

☐ No

Diagnosis

Dosing Regimen

Planned Duration of Therapy

3. Is the patient male?

If yes, proceed to Question 4.

If no, benefit is not approved.

☐ Yes

☐ No

4. Is sildenafil being prescribed for the treatment of primary erectile dysfunction (history of inability to ever achieve an erection)?

If yes, benefit coverage is not approved. Sildenafil has not been shown to be effective for the treatment of primary erectile dysfunction.

If no, proceed to Question 5.

☐ Yes

☐ No

5. Is sildenafil being prescribed for the treatment of impotence of organic origin? (Organic impotence is considered to include mixed organic/psychogenic and drug-induced erectile dysfunction when the causative drug cannot be reduced or discontinued. TRICARE regulations specifically exclude coverage of therapies for erectile dysfunction that is not of organic origin.)

If yes, benefit is approved for 1 year. Benefit coverage is limited to 6 tablets per 30 days or 18 tablets per 90 days.

If no, benefit coverage is not approved.

☐ Yes

☐ No

**Step 3** Please sign and date:

3

Prescriber Signature

Date

Latest revision: April 2003